

June 14, 2010

TO: Trion

RE: PPACA Grandfathering of Group Health Plans and Health Insurance Coverage –
Interim Final Rules

Section 1251 of the Patient Protection and Affordable Care Act (PPACA) provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of PPACA's enactment) are subject only to certain provisions of PPACA, and the statute refers to these plans as "grandfathered" health plans¹. However, the statute does not address the point at which changes to a grandfathered plan would be significant enough to cause the plan to cease to be grandfathered, leaving this issue to be addressed in regulatory guidance. On June 14, U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS) jointly issued "interim final regulations" (IFR) to provide more details about what constitutes a "grandfathered" plan under the statute. This memorandum provides an overview of the new rule and explains what types of changes will cause a plan to lose its grandfathered status.

Overview

There are certain market reforms in PPACA that "grandfathered" plans are not required to implement. This fact logically prompts the questions of how a grandfathered plan is defined, and what changes a plan could make and still maintain its status as grandfathered. In response to these and other critical questions, the IFR issued by HHS on this subject specifies (as explained in detail in the Analysis below):

- **Definition of a Grandfathered Plan.** A plan in existence on March 23, 2010 (the date of PPACA's enactment) is generally considered a grandfathered plan. The grandfather rules will apply separately to each benefit package made available by a plan, meaning that a single sponsor may offer grandfathered as well as non-grandfathered packages. Additionally –
 - a grandfathered plan may add new employees, or enroll new dependents, without losing grandfathered status;

¹ The word "plans" will be used in this memorandum as a short-hand reference to indicate both self-insured and insured employer-sponsored "group health plans." Recognizing that "health plan" has a particular meaning under various statutes that may exclude self-insured plans, use of the word "plan" here is not intended as a means of distinguishing between self-insured or insured arrangements. The grandfathering rules apply to self-insured as well as insured plans.

- a plan would not lose grandfathered status merely because some (or even all) individuals enrolled in the plan on March 23, 2010 cease to be enrolled, so long as the plan has continuously covered someone since March 23, 2010; and
 - grandfathered plan may make the changes required of it by PPACA and state law without losing grandfathered status.
- **Restrictions on Grandfathered Plans.** Doing any of the following will cause a grandfathered plan to lose its grandfathered status:
 - eliminating benefits – eliminating all or substantially all benefits to diagnose or treat a particular condition;
 - raising co-insurance charges – increasing a percentage cost-sharing requirement (such as coinsurance) above the level it was at on March 23, 2010;
 - raising co-pays “significantly” – compared with the copayments in effect on March 23, 2010, increasing those co-pays by more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation (as of March 23, 2010) plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status;
 - raising fixed-amount cost-sharing other than co-payments “significantly” – compared with the fixed-amount cost-sharing (e.g., deductibles, out-of-pocket limits) required as of March 23, 2010, increasing these amounts by a percentage equal to medical inflation plus 15 percentage points;
 - lowering employer contributions “significantly” – decreasing the percent of premiums or other fixed cost of coverage the employer or employee organization pays toward the cost of any tier of coverage for any class of similarly situated employees by more than 5 percentage points below the contribution rate that was in place on March 23, 2010, relative to the amount contributed by employees;
 - new or decreased annual limits – adding or tightening any annual dollar limit in place as of March 23, 2010. Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. Keep in mind that for plan years beginning after September 23, 2010, annual limits must be eliminated until HHS issues regulations on permissible ones;
 - changing insurance companies – if an employer decides to buy insurance from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when self-insured plans switch plan administrators and it does not apply to collective bargaining agreements;
 - requiring employees to switch plans to avoid compliance – if an employer requires employees to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing “as a means of avoiding new consumer protections,” grandfathered status will be revoked; or,

- sales or merger to avoid compliance – merging with or engaging in a sale to another plan to avoid complying with the law will cause grandfather status to be revoked.
- **Treatment of Coverage Maintained Under Collective Bargaining Agreements (CBAs).** The special implementation rule for CBAs ratified before March 23, 2010 – which delays implementation of the reforms until expiration of the CBA – does not apply to self-insured arrangements; it applies only to insured CBA arrangements. And with respect to insured arrangements that are subject to the special implementation rule, they will be treated like any other grandfathered plan once the CBA expires. Even more significantly, however, the IFR directs that all grandfathered CBA plans, insured and self-insured, must comply with the market reforms that apply to non-CBA grandfathered plans without a delayed effective date. This means that all CBA plans must implement changes such as the extension of dependent coverage to children up to age 26 and the ban on lifetime limits, the first plan year after September 23, 2010 regardless of when the CBA expires. Thus, the IFR effectively guts the special implementation rule for CBAs because it requires all CBA plans to comply at the same time as non-CBA plans even if the CBA has not yet expired.
- **New Disclosure and Recordkeeping Requirements.** Plans must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries, and must provide contact information for any questions or complaints about their grandfathered status. The IFR provides model language to assist plans with complying with this disclosure obligation. Grandfathered plans will also have recordkeeping obligations with respect to the information necessary to verify grandfathered status (e.g., records documenting the terms of the plan that were in effect on March 23, 2010) and must make such records available for examination by participants or regulators;
- **What Is Not Included.** What is not included among the restrictions on plans that wish to maintain grandfathered status are:
 - restrictions on the ability to change premiums;
 - prohibitions on changing plan structure, such as switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product);
 - restrictions on the ability to make changes in a plan’s provider network; or,
 - restrictions on the ability to make changes to a prescription drug formulary.

Note, however, that the IFR seeks comment on whether limits should be imposed on the ability of plans to make the foregoing types of changes.

- **Transition Rules and Good Faith Efforts to Comply.** The IFR advises that changes made under the following circumstances will not cause a plan to lose grandfathered status:
 - changes after the enactment of PPACA pursuant to a legally binding contract entered into before enactment;

- changes to the terms of health insurance coverage pursuant to a filing before March 23, 2010 with a State insurance department, that became effective after March 23, 2010; and
- changes pursuant to written amendments to a plan that were adopted prior to March 23, 2010.

The IFR also advises that for purposes of enforcement, HHS, DOL and the IRS will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan and policy terms that “only modestly exceed” those changes described in the grandfathering regulations that were adopted prior to publication of the IFR.

And plans will have an opportunity to revoke any changes that already have been made that would cause the plan to lose grandfathered status, so long as the changes are revoked, and the plan or health insurance coverage is modified, effective as of the first day of the first plan year beginning on or after September 23, 2010.

- **Additional Regulatory Guidance.** HHS explicitly advises that it may issue additional administrative guidance on grandfathering to deal with the manner in which plans make changes in response to this IFR, and such guidance could appear prior to adoption of final rules on grandfathering.

On other issues, the IFR also clarifies that:

- Retiree-only plans, as well as “excepted benefits” plans like dental-only and vision-only, are not required to implement the market reforms adopted in PPACA, and HHS urges states not to require such plans to do so; although,
- State laws that impose on health insurance issuers stricter requirements than those in PPACA will be not pre-empted by PPACA.

The IFR acknowledges that certain types of changes are routinely made by plans at annual renewal and purports to accommodate the ability to make “normal adjustments” such as premium fluctuations, changes in provider networks and drug formularies, changes in employer and employee contributions, and changes in covered items and services. Nonetheless, the IFR’s limitations on the ability to make changes to a plan while retaining grandfathered status, especially changes related to cost-sharing, co-insurance, and employer contributions, will undoubtedly cause great concern for employers.

Employers are urged, however, to make informed assessments of the particular impact that such restrictions would have on their plans, and to carefully weigh the costs versus the benefits of making changes that are perceived as critical but that would cause the plan to lose grandfathered status. Such an assessment necessarily includes an analysis of the costs of complying with the additional reforms that are imposed on “new” plans. If, for example, a grandfathered plan is already providing benefits such as free preventive care and coverage for participation in government-approved clinical trials, the plan sponsor may find that the cost advantages of being grandfathered are not as great as anticipated, and may not outweigh the advantage of making changes to cost structure that would result in loss of grandfathered status.

Because HHS sought to issue regulations on grandfathering in a relatively short time frame, the agency is issuing these regulations as “interim final” ones while providing an opportunity for public comment on the rules. Comments will be due 60 days from Federal Register publication of the IFR, i.e., the deadline will be on or about August 16, 2010 (the IFR is expected to be published in the Federal Register on June 17, 2010). The IFR is currently available at: http://www.federalregister.gov/OFRUpload/OFRData/2010-14487_PI.pdf.

Important details regarding the PPACA grandfather rules are discussed below.

Analysis **Application of the New Rules on Grandfathering**

A. Background – Reform Provisions that Grandfathered Plans Must Implement, and Those From Which Grandfathered Are Exempt

Preliminarily, it is useful to keep in mind that there are several market reforms that grandfathered plans must still comply with, which may make grandfathered status less valuable than one might anticipate. This is the case because PPACA, as originally adopted, would have exempted grandfathered plans from nearly all of the reforms. But the revisions made to PPACA by the Health Care and Education Affordability Reconciliation Act of 2010 (the “Reconciliation bill”) added many significant market reforms to the list of those that grandfathered plans cannot avoid.

The market reforms that all plans must implement, regardless of whether or not the plans are grandfathered, are:

- No lifetime coverage limits for “essential benefits”² (2010)³;
- No annual coverage limits on essential benefits except as may be permitted by HHS, from 2010 to 2014; after 2014, annual limits are completely prohibited;
- No pre-existing conditions exclusions (only applies to children younger than 19 from 2010 until 2014, and applies to all thereafter);
- A ban on policy rescissions except in cases of fraud (2010);

² Note that the list of specific “essential benefits” must be developed by HHS, although PPACA describes general categories of such benefits including, for example, emergency services, prescription drugs, and pediatric care.

³ References to “2010” in this list mean the reform must be implemented the first plan year after September 23, 2010. References to “2014” generally mean the reform must be implemented by January 1, 2014.

- Extension of dependent coverage until the dependent turns 26 years old (2014); from 2010 to 2014, grandfathered plans are only obligated to offer such coverage to those dependents who are not directly eligible for their own employer-provided coverage); and
- A bar on imposing waiting periods on plan participation in excess of 90 days (2014).

Non-grandfathered plans must comply with the following additional new requirements:

- Mandated offering of free preventative services (2010);
- Out-of-pocket limitations (equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts (2014);
- Primary care physician designation right for plan participants (2010);
- Clinical trial participation right (2014);
- Mandatory appeals process rights/notice (2010);
- Premium increase reviews (does not apply to self-insured plans) (2011);
- Plan quality reporting obligation to enrollees/HHS (2012).
- And all non-grandfathered small group (<100) and individual plans also must comply with the following two new requirements:
 - Provide “essential benefits” package and 60% minimum plan value (2014); and
 - Community rating/no medical underwriting (2014).

To the extent a grandfathered plan is already offering some of the benefits required only of “new” plans, such as free preventive care or coverage of participation in clinical trials, the savings that could be realized from being grandfathered would likely be reduced. The advantages of being grandfathered should be specifically assessed by plans and weighed against the benefits the plan seeks to achieve by making changes that would result in loss of grandfathered status.

B. Definition of a Grandfathered Plan

1. *Generally*

Section 1251 of PPACA, as modified by PPACA Section 10103 and amended by Section 2301 of the Reconciliation bill, describes a grandfathered plan as one in existence on March 23, 2010 (the date of PPACA’s enactment). Section 1251 also provides that a grandfathered plan may add new employees and/or new dependents without losing grandfathered status. The IFR warns, however, that if the principal purpose of a merger, acquisition or other restructuring is to cover new employees under a grandfathered plan, the plan will lose its grandfathered status. Employers also are prohibited from

requiring employees to switch from one grandfathered plan to another that has fewer benefits or higher cost-sharing than their previous plan in order to avoid application of the new market reforms.

Significantly, the IFR advises that if an employer or employee organization enters a new policy, certificate, or contract of insurance after March 23, 2010, this policy, certificate, or contract of insurance is not grandfathered. Moreover, any policy sold in the group market to new entities after March 23, 2010 is not grandfathered plan even if the particular product was offered in the group market before March 23, 2010.

Beyond these general provisions, the IFR specifies that the grandfather rules will apply separately to each benefit package made available by a plan, meaning that a single sponsor may offer grandfathered as well as non-grandfathered packages. In addition, a plan would not lose grandfathered status merely because some (or even all) individuals enrolled in the plan on March 23, 2010 cease to be enrolled, so long as the plan has continuously covered someone since March 23, 2010. Moreover, a grandfathered plan may make the changes required of it by PPACA and state law without losing grandfathered status.

2. *Coverage Under Collective Bargaining Agreements (CBAs)*

PPACA Section 1251(d) contains a special implementation rule for coverage maintained pursuant to CBAs ratified before March 23, 2010, specifically, that the market reforms will not apply to such coverage until expiration of the last CBA relating to the coverage. There has been considerable confusion about the meaning of this special rule for CBAs, such as whether CBA plans would be considered “new” or grandfathered after the CBA expires, and whether the special provision even applies to self-insured plans, given that the statutory language applies the special provision to “coverage” (which typically means insured arrangements) rather than “group health plans” (which can encompass self-insured arrangements).

Unfortunately, the IFR effectively removes any advantage CBA plans may have had in terms of a delay in implementation, through its interpretations of the text of PPACA and the Reconciliation bill. First, the IFR explains that the special implementation rule for CBAs applies only to insured arrangements and not self-insured ones. The IFR then goes on to direct that all grandfathered CBA plans – insured and self-insured – must comply with the market reforms that apply to non-CBA grandfathered plans without a delayed effective date, that is, regardless of whether and when the CBA expires.

This means that all CBA plans must implement changes such as the extension of dependent coverage to children up to age 26 and the ban on lifetime limits, the first plan year after September 23, 2010 regardless of when the CBA expires. If grandfathered CBA plans must comply with all of the reforms at the same time as non-CBA plans, there seems to be nothing left to which the delayed implementation would apply.

C. Restrictions on Grandfathered Plans

Much of the concern about grandfathering relates to questions about the changes a plan could make without losing grandfathered status. The IFR generally advises that the grandfathering rules will preclude changes that significantly reduce benefits or materially increase the cost of coverage borne by plan participants, or increase cost-sharing “in ways that might discourage participants from seeking

needed treatment.” On the other hand, the IFR purports to allow plans to make “reasonable changes routinely made” by plans or issuers, as well as additions to benefits and changes necessary to comply with PPACA.

Doing any of the following will cause a grandfathered plan to lose its grandfathered status:

- eliminating benefits – eliminating all or substantially all benefits to diagnose or treat a particular condition. For example, the IFR, states, if a plan provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the plan is treated as having eliminated all or substantially all benefits for that mental health condition;
- raising co-insurance charges – increasing a percentage cost-sharing requirement (such as coinsurance) above the level it was at on March 23, 2010. No increases in co-insurance percentages are permitted, according to the IFR, because these percentages already account for the rate of medical inflation;
- raising co-pays “significantly” – compared with the copayments in effect on March 23, 2010, increasing those co-pays by more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation (as of March 23, 2010)⁴ plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status;
- raising fixed-amount cost-sharing other than co-payments “significantly” – compared with the fixed-amount cost-sharing (e.g., deductibles, out-of-pocket limits) required as of March 23, 2010, increasing these amounts by a percentage equal to medical inflation plus 15 percentage points. HHS explains that given the rate of medical inflation in recent years, this formula would allow deductibles, for example, to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012;
- lowering employer contributions “significantly” – decreasing the percent of premiums or other fixed cost of coverage the employer or employee organization pays toward the cost of any tier of coverage for any class of similarly situated employees by more than 5 percentage points below the contribution rate that was in place on March 23, 2010, relative to the amount contributed by employees. For this purpose, the “contribution rate” is defined as the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. For insured plans, the total cost of coverage is determined in the same manner as the applicable premium is calculated under COBRA, and for self-insured plans, contributions by an employer or employee

⁴ “Medical inflation” is defined by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor.

organization are calculated by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage;

- new or decreased annual limits – adding or tightening any annual dollar limit in place as of March 23, 2010. Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. Keep in mind that for plan years beginning after September 23, 2010, annual limits must be eliminated until HHS issues regulations on permissible ones;
- changing insurance companies – if an employer decides to buy insurance from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when self-insured plans switch plan administrators and it does not apply to collective bargaining agreements;
- requiring employees to switch plans to avoid compliance – if an employer requires employees to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing “as a means of avoiding new consumer protections,” grandfathered status will be revoked; or,
- sales or merger to avoid compliance – merging with or engaging in a sale to another plan to avoid complying with the law will cause grandfather status to be revoked.

Employers should note what is not included in this list of restrictions for grandfathered plans, namely:

- restrictions on the ability to change premiums;
- prohibitions on changing plan structure, such as switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product);
- restrictions on the ability to make changes in a plan’s provider network; or,
- restrictions on the ability to make changes to a prescription drug formulary.

Note further, however, that the IFR seeks comment on whether limits should be imposed on the ability of plans to make the foregoing types of changes.

The IFR provides transitional rules for plans and issuers that made changes after the enactment of PPACA pursuant to a legally binding contract entered into before enactment, plans that made changes to the terms of health insurance coverage pursuant to a filing before March 23, 2010 with a State insurance department, or plans that made changes pursuant to written amendments to a plan that were adopted prior to March 23, 2010. If a plan or issuer makes changes in any of these instances, the changes will be considered part of the plan terms on March 23, 2010 even though they are not then effective. Therefore, such changes will not be taken into account in considering whether the plan remains grandfathered.

The IFR also advises that for purposes of enforcement, HHS, DOL and the IRS will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan and policy terms that “only modestly exceed” those changes described in the grandfathering regulations that were adopted prior to publication of the regulations.

For plans that desire to make changes to ensure compliance with the grandfathering rules, the IFR provides employers and issuers with a grace period within which to revoke or modify any changes adopted prior to publication of the regulations, where the changes might otherwise cause the plan to lose grandfather status. Under this rule, grandfather status is preserved if the changes are revoked, and the plan or health insurance coverage is modified, effective as of the first day of the first plan or policy year beginning on or after September 23, 2010 to bring the terms within the limits for retaining grandfather status in the IFR. For this purpose, and for purposes of the reasonable good faith standard changes will be considered to have been adopted before publication of the IFR if the changes are effective before that date, the changes are effective on or after that date pursuant to a legally binding contract entered into before that date, the changes are effective on or after that date pursuant to a filing before that date with a State insurance department, or the changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

D. New Disclosure and Recordkeeping Requirements

To maintain grandfathered status plans must comply with new disclosure and recordkeeping requirements. In terms of disclosure, plans must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries, and must provide contact information for any questions or complaints about their grandfathered status. The IFR provides the following model language to assist plans with complying with this disclosure obligation:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

Grandfathered plans will also have recordkeeping obligations with respect to the information necessary to verify grandfathered status, such as records documenting the terms of the plan that were in effect on March 23, 2010. Importantly, plans must make such records available for examination by participants or regulators.

E. Other Issues

The IFR addresses two seemingly unrelated issues, perhaps in an effort to clear up confusion about these issues sooner rather than later. First, to address considerable concern about whether the PPACA reforms apply to retiree-only plans or excepted benefits like dental-only, the IFR clarifies that such plans are not required to implement the market reforms. This means that provisions such as the requirement to extend dependent coverage to children up to age 26 do not apply to retiree-only plans and do not apply to dental-only and vision-only plans, and most health flexible spending arrangements. Furthermore, HHS urges states not to require that retiree-plans or excepted benefits plans comply with the market reforms.

At the same time, however, the IFR also clarifies that State laws that impose on health insurance issuers stricter requirements than those in PPACA will be not pre-empted by PPACA. Accordingly, to the extent states decide to require compliance by retiree-only plans and excepted benefits plans, such compliance would not be precluded by federal law.

F. Comment Period for the Grandfathering Rules

It should be kept in mind that HHS seeks comment on all aspects of the grandfathering rules, particularly the restrictions that plans must comply with to maintain grandfathered status. To the extent that Trion or its clients view these restrictions or other aspects of the rules as especially uninformed or problematic, there is an opportunity to offer such views to the agencies. Comments on the grandfathering IFR will be due 60 days after publication of the IFR in the Federal Register, i.e., on or about August 16, 2010.

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